OFFICE OF ADMINISTRATIVE OPERATIONS

QUALITY, OUTCOMES, AND TRAINING DIVISION – QUALITY IMPROVEMENT UNIT

COUNTYWIDE QUALITY IMPROVEMENT COMMITTEE (QIC)

MEETING MINUTES

December 2025

Type of meeting:	Monthly QIC Meeting	**Date:**	12/15/2025
Location:	Microsoft Teams	**Start time:**	9:00 AM
		End time:	10:30 AM
Recording:	Countywide QI Committee Meeting-20251215 - Jan 7th, 2026		
Members Present:	See Table Below.		
Agenda Item	**Presentation and Findings**	**Discussion, Recommendations, and/or Needed Actions**	**Person(s) Responsible**
I. Welcome and Introductions	Dr. Daiya Cunnane welcomed everyone and shared the meeting agenda and November 2025 meeting minutes.	Email any edits for the meeting minutes to DMHQI@dmh.lacounty.gov	Dr. Daiya Cunnane
II. MyHealthPointe Pilots	Andre Clinton shared LACDMH currently has over 1,000 enrolled clients in MyHealthPointe where clients have access to their records, allergies, labs, etc. There are over 700 providers and about 10-12 clinics enrolled. Rio	Dr. Cunnane shared the QI team has been using MyHealthPointe to see if it is a good platform for the Consumer Perception Survey (CPS).	Andre Clinton

	Hondo was the pilot clinic and has been working with the Chief Information Office Bureau (CIOB) since the initial pilot on implementation of any new features. CIOB has been onboarding our clinics for the last year and has started to focus on more of the enhancements. The MyHealthPointe client portal is structured by clinic program and care team. It is a secure portal, and users must have credentials. Clients that have consent on file indicate a notification preference, and by default, CIOB sets the profiles text and e-mail. CIOB would like to expand next year to the regional level and send messages out, flyers, and announcements. New features include medical records requests, client self-registration, clicking on QR code or scanning it to build their own profile and select options for notification preference. This is available on the Rio Hondo clinic page and flyers. CIOB has been working toward verification by date of birth and telephone	Carol Sagusti wondered how accessible tech support will be for people who have difficulty and will it be through Andre Clinton's team or the clinic itself. Andre Clinton shared that the primary IT support will be provided by the clinic if there are accessibilities issues, but CIOB supports the clinics. CIOB discussed accessibility issues with the CPS team and has a mandate to go through a process of getting it certified by early next year. Dr. Daiya Cunnane asked if CIOB has recorded trainings for staff to view, or if it is something that will be done in the future. Andre Clinton stated, we have a SharePoint site. The link will take you to a SharePoint documentation library, where it has	

	number. CIOB will send client credentials either by their phone number or e-mail address. The MyHealthPointe portal also has virtual patient check-in where clients show up in the clinic for their appointment, a staff member will be in the lobby with a tablet or at a desktop, and staff can see all the appointments for that day. At Rio Hondo, we have a kiosk to be set up in the lobby, and clients have two ways of checking in, either at the front desk or at the kiosk and check themselves in. Clients' ability to sign documents is a big deal for financial services as financial staff complete yearly screenings. Clients can sign the screenings electronically, it will go right back to the care team, and clients will be notified via text and e-mail the same way. Providers and care teams will be notified through Outlook. For patient self-schedule, CIOB hopes to have the features in place during the second quarter of next year where our patients can schedule themselves at our clinics. There will be a screen	videos about on-boarding, virtual check in, and using shared calendars to keep up with office hours. If you have a question, we can accommodate you for that. Dr. Socorro Gertmenian asked does the system differentiate between those who give consent for those features and those who do not? Part of our struggle has been to ensure that we have consent for texting and emailing. Andre Clinton shared that CIOB did not rely on the clinics to onboard our clients. CIOB used the clinics active client list and filtered the lists to clients who had a consent on file and wanted to be contacted by text or e-mail. This procedure was completed in the first 90 days when CIOB onboards clinics. After, clinics are on their	

	that will have around six providers, or whoever is working that day, and clients can choose between telehealth and physical appointments. Clients will be able to see their allergies, encounters, lab results, medications, documents, surveys and assessments, and education. For medical records, clients will be asked in what language they would like the request to be completed. Currently, there is only English and Spanish. If clients choose Spanish, the documents will be translated. If other languages are requested, they will have to be built into the portal. The portal cannot accommodate third party requests at this time, and the medical records request is only for adults 18 to 60+ years old. The request will go into the document folder, wait for review, and will need to be signed. Clients will receive notification via text and e-mail that they have a document uploaded to the client portal, and it gives them the link to get the request. Clients can fill out requests on a desktop in the clinic and sign using their	own and do enrollments through the new features. Clinics will be able to set their own notifications. If clients want to be contacted, there will have to be a consent on file. Dr. Socorro Gertmenian shared that her clinic's struggle has been making sure that they are not emailing or texting clients who do not want to be contacted in that way, especially when we have minor clients. She stated that this information helps a lot. Andre Clinton added that there is a recent change that the client can turn off notifications if they do not want to be notified of an appointment with an email reminder or text message. Neither CIOB nor the clinic cannot turn it	

	finger or mouse. Once signed, the request goes to medical records, and the team is notified through Outlook. The medical records team will have their own dashboard to see the request come in, and on the right side, staff will see all the requests for each client and the ones that were completed. The staff from medical records who started that task will take responsibility for completing the medical records request. If staff are on vacation, another staff can click on "action" then "start the task." That staff will take responsibility. The medical records team will go into Avatar and get the PDF, download the medical records, upload, and save the record. Only the medical records team and providers can control the client's library. What CIOB hopes to accomplish with this process is cutting down the request time from 15 to 5 days and removing the task from the clinic, if they choose. At Rio Hondo, I think they have two people who complete medical records almost full time, and the clinic can still choose to do that.	back on unless the client contacts the clinic. Carol Sagusti shared, specifically for field-based clients, her team is the older adult Geriatric Evaluation Networks Encompassing Services Intervention Support (GENSIS) program, and there could be some difficulty learning the system. "Is there a possibility that staff can be trained by CIOB to use this system?" Andre Clinton shared that CIOB tries to accommodate the workflow for the clinic or program, and it can be customizable. We can create care teams that your program needs. We can do them by location and different levels of access. Carol Sagusti asked if she could invite Andre Clinton, or one of the	

	The client appointment dashboard is live in Rio Hondo and in real time. There are documents, forms, assessments, so if there's anything that staff sent to the client, they can either sign documents or see if they need to fill out including medical records, financial forms such as the financial obligation agreement, Payer Financial Information (PFI) forms, third party extended authorization, and client authorization. These are the four main financial forms that were built for Rio Hondo. The assessments are mapped back to Avatar for Patient Health Questionnaire 9 (PHQ-9), the PHQ for Adolescents (PHQ-A) and the Generalized Anxiety Disorder 7 (GAD-7) are mapped back to the care record. It can be sent out within 24 hours, or 48 hours before the pre-visit. The portal will send out the PHQ-9 before clients come to the office. If a client schedules an appointment, they will do their assessment, and it goes to the care team. There is also feedback form sent 24 hours after the visit that	team, to a staff meeting and review it with the team. Andre Clinton stated that would be no problem. Dr. Daiya Cunnane shared that for the CPS, clients might not be able to use the features. QI discussed with Peer Services about peers helping clients to complete the survey or providing general education to clients or family members on how to interact and utilize the portal. Andrew Nguyen asked about client self-scheduling appointments and self-selecting providers. “Where is it in the process of implementation or is it already live?” Andre Clinton stated CIOB is targeting the second Quarter (Q2). There are a lot of discussions, and	

	asks three or four questions for feedback that goes to the care team. CIOB aims to enroll 2,000 clients by December 2026. Please send CIOB an email if you have any questions, if you want to set up a demo for your clinic, or just need a little bit more involvement. Thank you very much.	it is in the concept stages. It will be the last thing implemented. CIOB does have a demo, and there are a lot of features and great possibilities. It needs to be structured and LACDMH needs to have a lot of discussion around it. Andrew Nguyen asked if their team could be included in those discussions. Andre Clinton stated that LACDMH is the pilot for Netsmart. LACDMH is the first to roll them out, and CIOB is working and meeting with the Netsmart product team once or twice a week. 93% of the clients in the clinics would prefer text or email instead of having a home phone number as contact. However, communication will not start until the client signs in for their credentials and a message	

		says that we have 24 hours to answer their message. For medical emergencies, it states to dial 911. There must also be user agreement privacy placed in their document folder.	
III. Service Area 2 Care Coordination Quality Improvement Project (QIP)	Dr. Shayan Rab shared there is very little innovation that takes place when it comes to involuntary holds, but there is a system, and a lot of the clients that we serve are severely mentally ill (SMI) and require Specialty Mental Health Services (SMHS). Many of the clients are unhoused, too many systems of care are involved, and each system makes interventions based on its own protocols or workflows that might not help transform life for the individual that is being placed on a hold. This pilot is called the Service Area (SA) 2 Care Coordination pilot. The goal is to develop new strategies for involuntary mental health hold care coordination with the goal of integrating services and promoting readiness for Senate	Dr. Daiya Cunnane shared this is a very exciting project as it focused on improving the coordination of care, and hopefully, the treatment outcomes of the clients involved. It can also help improve our rates for follow-up care after hospitalization, so there are many ways that this project can help improve services for LACDMH. Dr. Daiya Cunnane thanked Dr. Shyan Rab and Antonio Banuelos for presenting the project. It shows that by simply increasing communication can make a big difference in treatment outcomes.	Dr. Shayan Rab/ Antonio Banuelos

	Bill (SB43), a bill that expands the definition of Grave Disability and that mental illness has kept the individual from providing for food, clothing, or shelter for themselves. It is going to expand to be redefined as someone who has a mental illness or a substance use disorder (SUD), or both occurring at the same time and a result of this mental illness or SUD, the individual is unable to provide for their food, clothing, shelter, personal safety and medical care. This pilot was initially designed to test for how our theoretical analysis of how holds should move to the system and translate into clinical practice. Just a reminder that the team did not use the expanded definition of Grave Disability but pivoted to something that is a little bit more important than the expanded definition, and that is the topic of care coordination. It is important to know how LACDMH as a system does, respond to hold, how do we break revolving doors, and how do we coordinate care. The Homeless Outreach & Mobile Engagement (HOME) Team has been doing	Dr. Michele Renfrow shared just to add that each SA is going to create their version of this and with hospital liaisons in those SAs. We are meeting with SA 2 this week to try to do some version of this in every SA. Antonio Banuelos thanked the QI team, Dr. Kara Taguchi, and Stacey Smith for connecting us and for your support. One of the things that stood out regarding this model is that the team let it take its course and stepped away. What the Care Coordination model and the Home Team have been practicing is making connections. From the time of the hold to the acute care treatment, and to discharge demonstrating to be successful. Hopefully our system will adapt to this at some level to improve the care quality of our	

	this for quite some time and has been able to show a dramatic reduction in return to the street, a dramatic improvement in outcomes by centrally coordinating care, and when this pilot opportunity came around, the team decided to use the HOME Team model on a much larger scale. The team studied what happens when a central monitor holds and assesses how individuals are moving through different systems of care. The most important pilot goal was to centrally track the flow and mapping of 12 clients, six who were housed and six who were unhoused, who were being placed on a mental health hold over a two-month period to see how these cases were moving to the system and improve outcomes. Not only did the team monitor the holds but created a weekly meeting space where providers could discuss these cases, share new resources coming online, create a space for teams to learn together, talk about the pin points that were experienced, and come up with new ways to move forward, and use secure e-mail as a	customers, especially the ones that are struggling and cycling back into the hospital. Dr. Shyan Rab thanked the QI Team as this is first real data that the team has on how to break revolving doors, and now we finally have one.	

	means of communication. When having multiple systems of care, not everybody has the same tools available to them, but everyone has emails, so the team decided to use secure emails to communicate care plans across multiple systems of care and not rely on verbal reports as it would be better to centrally notify key players at each level of care to have a shared understanding of what needed to take place. The team also wanted to integrate services for mental health, for substance use, and for physical health because there are other things that are also taking place that are affecting the individual's overall health. It is important that providers identify housing and linkage needs at the start of the admission as housing status is not something that hospitals think about until the day of discharge. Providers want to get a head start on looking at the housing status of someone and their outpatient linkage need at the very start of the hospitalization and work on addressing those during the hospitalization so they would have a		

	foundation to stand on. Once they return to the outpatient, the team would like to adjust the flow and mapping of clients who were stuck in revolving doors to break the cycles that prevent giving clients transformative interventions. Ultimately, as with all pilots, the team wanted to build new relationships within the space and identify areas for future development. Antonio stated that SB43 is very specific to the adult population therefore this pilot was also focused on the adult population only. Dr. Shyan Rab shared how the team implemented the QIP by looking at what are some considerations we keep in mind when we are talking about system flow and mapping. Whenever an involuntary hold is taking place, the first thing is hold criteria itself as these are the legal criteria that must always be considered when starting a 5150. Is the criteria Dangers to Self, Danger to Others, and Grave Disability (reminder we are using the traditional definition, not the new one)? The next		

	consideration is service needs. Does this person just have pure mental health needs? Do they have substance use needs? Do they have physical health concerns that we that we need to address? This is important because if somebody is psychotic, delusional, and neglecting a terrible wound on their leg that could result in an amputation. They are not going to go to a mental health urgent care for crisis stabilization. Instead, they need to go to an Emergency Room (ER). Therefore, there is a legal and clinical consideration taking place, so this is where traditionally the considerations would stop. What providers want to do is add a third layer of consideration, which is the housing status of someone who is coming in to create different lines of care within the acute care system for people who are housed versus those who are unhoused, and who are linked to outpatient services/outreach services, and those who are not. This is a key step as it creates a novel pathway for people who are unhoused and unlinked to services, which is		

	what most hospitals do not generally make. Providers want to identify that early because the housing does take some time, and providers cannot convince someone to get housed on the day of discharge, but it might be better able to convince them about housing on day one start of the admission. Also, by getting their right LACDMH team on board before they are coming out to ensure that they have a smooth transition to the outpatient service. This is very critical consideration, but rarely ever happens where HOME Team is the one that starts this process. We wanted to generalize it to the rest of the pilot participants. Working in the pilot included LACDMH, Department of Health Services (DHS), Department of Public Health (DPH), and private partners. Within LACDMH we have Psychiatric Mobile Response Team (PMRT), HOME team, field-based providers, clinics, hospital liaisons, the Public Guardian, Intensive Care Division (ICD), our housing and job development divisions from DHS, interim housing providers,		

	outreach providers, County hospitals from DPH, and DPH Substance Abuse Prevention and Control (SAPC) contracted partners like Tarzana Treatment Center and Cry Help. We also had a lot of private hospitals including Mission Community, Glendale Adventist, Henry Mayo, and Pacifica Urgent Care Center. Although we have many participants mentioned, they are not very client centered so the team reorganized all of this into the actual services that the individual needs, which would be outreach or field-based services, clinic-based services, housing and residential services, acute care services, care coordination support, court related, and crisis response. We have created a master contact list for the pilot and divided them into categories to call for what type of service is needed. Antonio Banuleos shared the list overtime grew, and as the word got out, there were quite a few partners and service types that we were not		

	completely considering at the initial start of the pilot, and this was a great experience. Dr. Shyan Rab shared another partner to join the table was Emergency Medical Services (EMS). We had the Fire Department join us as they are another side of involuntary calls that we do not often integrate with much, but they joined and we ran our list with them to see if there was any overlap with the calls that were being generated in SA 2 for EMS, which were mental health situations. We created a Monitoring Team for this pilot, and the job of this team was to get notifications when holds were taking place and then integrate all key players to monitor that hold as it moved through different systems. We had a lot of expert minds at the table who were monitoring the hold to see what the best fit would be, and that was key. The role of the monitor is to centrally track the holds to receive the referrals from the people who were starting the hold and integrate all the key players that		

	were needed to be at the table by gathering data about the patients being placed on hold and creating virtual secure emails. The pilot monitor also held weekly meetings and during each meeting a new developing service or an underutilized service needed to be integrated with a larger system was highlighted. We also provided general consultation to all the pilot participants. Our workflow was simple, we had hold initiation before the hospital, during the hospitalization we were doing acute care collaboration, and after hospitalization we were doing outpatient follow up. Whenever an identified team started a hold in Service Area 2, we looked at if PMRT, FSP, Home Team, and clinic were the only hold initiators. If approved, hold initiators for this pilot would send an e-mail to the pilot monitor and they would see if the case made sense, then we would connect and take all the people involved in the client's Outpatient care and start connecting them with the hospital where this individual went. The pilot monitors job was to		

	make sure that the Outpatient and Inpatient services discussed together and shared resources to make sure that the outpatient plan for this individual made sense. We also made sure that housing and linkage status was identified and addressed from day one of admission, and not on the last day of admission. We made sure case management and navigational support was being provided early and reminded Acute Care providers and Outpatient providers to communicate with each other and shape the outcome of this admission. We encouraged if client is unhoused the discharge planning for this individual included at an appropriate housing plan. The hospitals were limited and not familiar with housing options and resources. A lot of the housing options that hospitals find require abstinence and they need programs that are more flexible. If somebody was unlinked, we educated the Inpatient team on how to best reactivate Outpatient services and what resources were available to make appointments ahead of time		

	and figure out the right clinic. If patients refused both housing and linkage support, pilot monitor educated all providers on how this might be the time to activate outreach services once someone is discharged in the street and work on their readiness for these services over time. This way, no matter what pathway the patient went down, there was a solution to mitigate the risk of someone coming out of a hospitalization without any follow up or resources available to them to transform their lives. The pilot monitor was also available for consultation throughout each patient's admission, just in case expert advice was needed on how to navigate cases. The last phase is Outpatient follow up. We wanted there to be a clinically supervised transition from Inpatient care to Outpatient care to make sure that there is a warm hand off. This includes handling discharge paperwork, discussions from doctor to doctor making sure there was a shared understanding of what needed to happen, and that housing and linkage needs were met. We also did a follow		

	up a couple of weeks to a month after somebody came out of the hospital to make sure that they attended their Outpatient appointments and were linked to a new provider who could continue their care. We do have data on the outcomes as the pilot is now over and ended in November. We did a survey of everybody who was involved and about 92% of the respondents found the real time case consultations were very helpful and some of the respondents requested more time to consult on challenging cases and supported the expansion of this pilot. They wanted more time to talk about their cases. About 76% of the respondents reported that they learned about new resources that they never knew about, especially when it came to serving people who were unhoused. Homeless services are developing outside of Acute Care for quite some time, and this is new to Inpatient providers, and they were very excited to learn about better housing resources to better discharge planning and prevent them from		

	coming back. Next is 100% of Outpatient providers found emails to be very effective as a means of communication. Not all Acute Care providers felt the same and preferred phone calls because they are not always sitting at a desk and when in the hospital, emails are a little bit more challenging. We met in the middle on this in the pilot, where we advised the Outpatient provider to document and send a general e-mail update whenever they spoke to an Acute Care provider within the secure e-mail thread so this way everybody was aware of the conversations taking place. Antonio Banuelos shared we received feedback and there are a lot of lessons learned, a lot of experiences that we documented, but this is just some of the information that supports this Care Coordination model approach. Dr. Shayan Rab shared our pilot had 12 patients who were in Service Area 2 and were placed on a 5150 hold between September and October. We compared those to 12 individuals,		

	to 6 housed and 6 unhoused patients placed on holds in Service Area 8, in the same time frame. The comparison group was matched on age and housing status. For the 12 people that we had in our pilot, 11 were admitted to Acute Psychiatric units, 1 still remains on an Acute Psychiatric unit, 1 individual was lost during transport and is still missing, and 1 individual left Against Medical Advise (AMA) once the hold was taken off and was subsequently incarcerated. Looking at total of 9 pilot participants, none were re-hospitalized in 30 days. For comparison group, half of them were re-hospitalized within 30 days after discharge. When it comes to linkage to Outpatient providers, out of our 12 pilot participants, 8 were linked to Outpatient services upon discharge, and for the comparison group only 3 people were linked, so we had a much better outcome. Although the pilot is over, the data shows that Acute Care collaboration can significantly improve outcomes for people who are being put		

	on holds and the Care Coordination provided by the Service Area 2 team will now be provided by our Countywide hospital liaison system that will be run by Dr. Michelle Renfrow where each Service Area will have its own Care Coordination, doing the same what the pilot did and in collaboration with the Service Area Chiefs. Our pilot was successful as we had a regular meeting space for all service providers in Service Area 2 to discuss cases, we had interagency Care Coordination that was written rather than just verbally provided to help foster a shared understanding of recovery needs, and we had family or clinical supervision of people coming out of the hospital so that there was oversight of someone who was severely mentally ill and supported transition to the Outpatient service. There was also increased awareness of different services available that the Service Area did not generally know about, especially at the Acute Care level. We did clinically supervised transportation to make		

	sure when somebody left the hospital, they made it to their housing or returned to their family or had resources at least available to attend to their next appointment.		

Next Meeting: Monday, January 12, 2025, from 9:00AM-10:00AM

Attendance (below):

NAME	AGENCY
Kara Taguchi	DMH-QI/Outcomes
Stacey Anne Smith	DMH-Quality Improvement
Daiya Cunnane	DMH-Quality Improvement
Barbara Meyer	DMH-Quality Improvement
Marianne Klee	DMH-Quality Improvement
Angelle Hill-Seetal	DMH-Quality Improvement
Alan Wu	ARISE Division
Andre Clinton	DMH- Chief Information Office Bureau (CIOB)
Andrew Nguyen	Pharmacy
Angela Shields	Specialized Foster Care South
Antonio Banuelos	SA 2 Chief

Berteil Eishoei	Quality Assurance
Brian Dow	Quality Assurance
Carol Sagusti	Older Adult Services / GENESIS
Carrie Helgeson	CCR
Elizabeth Powers	CMMD
Greg Tchakmakjian	SA 7
Jennifer Hallman	Quality Assurance
Jennifer Mize	SA 1
Julie Garcia	OCS North County
Kimber Salvaggio	Training Division/ SA 2
Lori Willis	Children's
Michelle Renfrow	Hospital Liaison
Michellle Rittel	SA 2
Rachel Santellan	SAPC
Robin Ramirez	MHSA Division
Sandra Chang	ARISE Division
Sharon Chapman	DMH-Outcomes
Shayan Rab	DMH-Psychiatry
Socorro Gertmenian	SA 7
Susan Blackwell	HAI - Planning

Susan Cozolino	Quality Assurance
Theodore Wilson	Patients' Rights
Tiffany Trotter	SAPC
Toni Robinson	Peers Services
Venezia Mojarro	Compliance, Privacy and Audit Services
Wanyu Chang	PEI Admin
Yen-Jui Ray Lin	Clinical Informatics

Respectfully Submitted,

Dr. Kara Taguchi